F 6/29/ED

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G211	A. BUILDING _____ B. WING _____	05/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HRDI OF THE DISTRICT OF COLUMBIA, LLC	3073 VISTA STREET, NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This recertification survey was conducted from May 22, through May 24, 2007. The survey was initiated using the fundamental survey process; however, it was determined that an extended process should be implemented under the conditions level of participation of client protection and active treatment. Based on the findings of the extended survey a full survey was implemented to review governing body and staffing. A random sample of three clients was initially selected from a residential population of six females. An additional client was added to the sample as a focus. All clients in the sample had diagnoses of profound mental retardation. One of the six clients was blind. Three clients in the facility had psychiatric diagnoses for which medications were prescribed. The clients in this facility had limited to no skills in verbal communications. The findings of this survey were based on observations at the facility and day programs ,staff interviews at both the facility and day programs, review of clinical, medical, and administrative records to include the facility's unusual incident reports and policies. As a result of the survey findings it was determined that the facility was not in compliance at the Condition Level of Participation under Client Protection.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	W102 Cross Reference W104	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

6/28/07

v deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1 This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility [Refer to W104]. The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the condition of Client Protections [See W122].	W 102	1. On October 2, 2006, HRDI established policy governing our agency's Human Rights Committee ensuring that all aspects of facility practices are reviewed to affirm and protect client rights. (See attached human rights policy and client rights policy.)	10/2/06 & Ongoing
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body fail to provide general operating direction over the facility. The findings include: 1. The governing body failed to ensure that its specially-constituted committee (Human Rights Committee) reviewed all aspects of facility practices, to affirm and protect clients' rights. [See 124, W262, and W263] 2. The Governing Body failed to establish and implement policies and procedures to ensure that injuries of unknown origin were reported immediately to the administrator and the State agency. [See W149 and W153]	W 104	2-3 On October 1, 2006 HRDI after receiving the Department on Disabilities policy on incident reporting of injuries of unknown origins aligned its internal policy with that of DDS. However it was brought to our attention during the course of this survey that DDS' policy was not in alignment with the Department of Health. As a result HRDI promptly changed its policy for notifying and reporting incidents to correspond with the federal guidelines. Furthermore, all management staff have been trained on the revised policy and direct support staff will be trained by August 30, 2007 during our agency's annual training sessions. (See attached policy which dictates that all incidents are to be thoroughly investigated with the and followed up on. A copy of which should be sent to the Administrator within 72 hours and to the state agency within 5 business days.	10/1/06 & Ongoing

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W 104	Continued From page 2 3. The Governing Body failed to establish and implement policies and procedures to ensure that injuries of unknown origin were thoroughly investigated. [See W154] 4. The Governing Body failed to establish and implement policies and procedures to ensure that clients receiving psychotropic medications for the treatment of Axis 1 diagnoses received comprehensive psychiatric assessments [See W212] 5. The Governing Body failed to establish and/or implement policies and procedures to ensure sufficient direct care staff to manage and supervise clients while being transported. [See W186]	W 104	4. On May 30, 2007 HRDI amended it's policies and procedures to ensure that clients receiving psychotropic medications for treatment with Axis 1 diagnosis receive comprehensive psychiatric assessments and all management staff have been in-serviced on the policy. (See attached policy and in-service) Furthermore as of June 18, 2007 all individuals residing in the home with an Axis 1 diagnosis receiving medication have received a comprehensive psychiatric assessment (See Attached Assessments) Additionally the new assessment along with drug regimen will be presented at the next agency scheduled Human Rights Committee Meeting on June 27, 2007.	6/27/07 & Ongoing
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, interview, and record review the facility failed to to ensure the right of legal representative to be informed of the client's medical condition, attendant risks of treatment, and the right to refuse treatment [See W124]; failed to ensure that a system had been developed to inform each client of the right to refuse treatment [See W125]; failed to establish and implement policies that ensure each client's health and safety [See W149]; failed to notify the designated Administrator and other officials of all injuries of unknown origin [See W153]; failed to document the provision of thorough investigations of injuries of unknown origin [See W154]; failed to	W 122	5. On April 1, 2007 HRDI did establish policy and procedures to ensure sufficient direct care staff manage and supervise clients while being transported. (See attached policy) Additionally all HRDI staff will be in-serviced on this policy during our annual trainings July 16-20, 2007	7/20/07 & Ongoing

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W 122	Continued From page 3 ensure that investigations were reported to the administrator or designated representative with in five working days of the incident [See W156]; the facility failed to ensure that one of three clients in the sample who was receiving psychotropic medications had a psychiatric assessment [See W212]; facility's Human Rights Committee (HRC) failed to review, approve, and monitor the use of psychotropic medications to manage inappropriate behaviors [See W262] and failed to ensure that restrictive programs were used only with written consents. [Refer to W263] The effects of these systemic practices results in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being.	W 122	W122 On May 30, 2007 HRDI's administrator reviewed all incidents for the home and provided feedback and follow-up. As previously stated there was some unclearity about the reporting of incidents based on a policy distributed by the Department on Disabilities. However all HRDI management staff have been re-in-serviced as to the proper protocol for reporting incidents.	5/30/07 & Ongoing
√W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of six clients residing in the facility. (Client #3 and #4)	W 124		

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W 124	Continued From page 4 The findings include: 1. Observation of the evening medication administration conducted on 5/22/07 at beginning at 4:50 PM, revealed Client #3 received Risperdal 1 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 4:57 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 8:49 AM revealed that Risperdal 1 mg by mouth Q PM was incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head rubbing, self-harm, and uncooperativeness. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on 5/23/07 at approximately 11:12 AM revealed that Client #3 did not have a legal guardian, but her sister used to be involved in her life. The House Manager indicated that the facility has not been able to contact the sister. Review of Client #3's Psychological Assessment dated 11/30/06 on 5/23/07 at approximately 11:35 AM revealed that she is unable to give informed consent and requires 24-hours a day supervision in a group home in order to function in a community setting. The assessment also revealed that Client #3 is not competent to make independent decisions concerning her treatment, placement, or finances. There was no documented evidence that the facility informed Client #3 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or	W 124	1-2 HRDI has a system in place for clients and their significant circle of support to be informed of the use of restrictive medications. Clients #3 and #4 have been informed of their restrictive medications risks and benefits. The Human Rights Committee has also reviewed and approved the use of Risperdal 1mg (for Client #3), Buspar 15mg, Tegretol 200mg and Revia 25mg (for Client #4) and this was done as the committee evaluated the fact that the benefits outweigh the risks at this time. Furthermore, the facility has made provisions to contact a legally recognized individual for a consent for both individuals. 6/30/07	6/30/07 & Ongoing

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W 124	Continued From page 5 entity. 2. Observation of the evening medication administration conducted on 5/22/07 at 5:31 PM, revealed Client #4 received Risperdal 2 mg, Buspar 15 mg, Tegretol 200 mg, and Revia 25 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 5:35 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 10:16 AM revealed that the psychotropic medications were incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head banging and self-injurious behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on 5/23/07 at approximately 11:12 AM revealed that Client #4 did not have a legal guardian, but her sister and father is involved in her life. Review of Client #4's Psychological Assessment dated 11/30/06 on 5/23/07 at approximately 12:30 PM revealed that she is unable to give informed consent and requires 24-hours a day supervision. The assessment also revealed that Client #4 is not competent to make independent decisions concerning her treatment, placement, or finances. There was no documented evidence that the facility informed Client #4 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124	1-2 HRDI has a system in place for clients and their significant circle of support to be informed of the use of restrictive medications. Clients #3 and #4 have been informed of their restrictive medications risks and benefits. The Human Rights Committee has also reviewed and approved the use of Risperdal 1mg (for Client #3), Buspar 15mg, Tegretol 200mg and Revia 25mg (for Client #4) and this was done as the committee evaluated the fact that the benefits outweigh the risks at this time. Furthermore, the facility has made provisions to contact a legally recognized individual for a consent for both individuals. 6/30/07	6/30/07 & Ongoing
W 125	483.420(a)(3) PROTECTION OF CLIENTS	W 125		

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W 125	Continued From page 6 RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that individuals who lacked the capacity to make informed decisions had received assistance with identifying a surrogate decision-maker for habilitation and treatment needs, for two of four clients residing in the facility. (Client #3 and #4) The findings include: The facility failed to ensure clients' rights were protected by making certain each client had a legally sanctioned representative to assist them with making decisions regarding their treatment. [See W124]	W 125	W125 Cross Reference W124	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on the review of incident reports, interview with the Qualified Mental Retardation Professional, and review of the facility's policy, the facility failed to implement policies that ensured	W 149		

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W 149	Continued From page 7 the continuous protection of clients in the facility. The findings includes: 1. The facility failed to implement its policies and procedures for reporting incidents as evidence below: a. On 5/14/07, Staff entered Client #3's room after she returned home from the day program and notice that she had scrapes on her left elbow and palm. Upon further observations when assisting the with personal care, staff notice that she also had scrape marks on her knee. Interview with the facility's Registered Nurse on 5/22/07 at approximately 2:40 PM revealed that the nurse had assessed and cleaned the injuries. There was no evidence of a signature or date on the incident report indicating when the nurse cleaned the injuries. b. According to the facility's driver on 4/30/07, she witnessed Client #4 grabbing #3's face with her hands and scratching her while transporting the clients. "I stop the van because she was the only staff and attended to it, but at this time, blood was already coming out from the scratch area and I had to proceed with the driving to pick up another staff for the van run. Three (3) scratches notice on the right side of cheek". c. On 4/3/07, staff helping Client #3 undress for shower when noticing a bruise on left should under her bra strap about the size of a nickel. According to the incident report, there was no evidence that a nurse had assessed the bruise and/or notified. d. On 11/6/06, while preparing for a shower, staff	W 149	P7 W149 1. a-g The staff will be trained by the QMRP to report each incident observed on a client per HRDI policy and procedure. The QMRP will ensure that appropriate coordination and follow up is done regarding each reported incident. Staff will be trained to properly complete an incident report whenever an incident occurs. The QMRP will provide proper follow up after an incident is reported. Cross Reference W153 6/28/07	6/28/07 & Ongoing

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W 149	Continued From page 8 notice a red circle on both thighs grape size marks, about one (1) inch long on Client #6. Etiology unknown. e. On 10/4/06, Client #6 was transported to Providence Hospital via residential van. LPN assessed the client as having swollen ankles and instructed staff to take the client to the emergency room for further evaluation. f. On 9/1/06, Client #6 was discovered by the day program staff to have a raised area on her forehead. Staff did not know how the injury occurred, therefore it is an injury of unknown origin. g. A nursing progress note, dated 5/19/07, revealed that Client #4 sustained a bruise on the right arm. Review of the facility's "Incident Management System" on 5/22/07 at approximately 2:45 PM revealed that "The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures." [See W153] 2. The facility failed to implement its policies and procedures for investigating injuries of unknown origin and/or injuries that was discovered as evidence below: a. On 5/14/07, Staff entered Client #3's room after she returned home from the day program and notice that she had scrapes on her left elbow and palm. Upon further observations when changing her, staff also notice that she also had	W 149	2 a-f The QMRP will be trained to thoroughly investigate all incidents of unknown origin-both Reportable and Serious Reportable incidents. In future, the provider will ensure that the Incident Management Coordinator and the QMRP will obtain pertinent information to investigate each incident that occurs. Cross Reference W154 6/28/07 Ongoing	6/28/07 & Ongoing

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W 149	Continued From page 9 scrape marks on her knee. There was no evidence that an investigation had been conducted to determine the cause of the injuries. b. On 4/3/07, staff helping Client #3 undress for shower noticed a bruise on left should under her bra strap about the size of a nickel. There is no evidence that the injury of unknown origin was investigated. c. On 11/6/06, while preparing for a shower, staff notice a red circle on both thighs grape size marks, about one (1) inch long on Client #6. Etiology unknown. According to the incident report, the incident was investigated on 11/6/06; however, there is no evidence of an investigation report in the records. d. On 10/4/06, Client #6 was transported to Providence Hospital via residential van. LPN assessed the client this morning during the medication pass as having swollen ankles and instructed staff to take her to the emergency room for further evaluation. According to the incident report, the incident was investigated; however, there is no evidence of an investigation report in the records. e. On 9/1/06, Client #6 was discovered by the day program staff to have a raised area on her forehead. Staff did not know how the injury occurred, therefore it is an injury of unknown origin. An investigation report for this injury was given to the surveyor on the last day of the survey. This incident was investigated by the local agency; however, there was no evidence that the facility had conducted it's own internal investigation.	W 149		

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W 149	Continued From page 10 f. A nursing progress note, dated 5/19/07, revealed that Client #4 sustained a bruise on the right arm. There was no evidence that an investigation had been conducted to determine the cause of the injuries. Review of the facility's "Incident Management System (IMS)" on 5/22/07 at approximately 2:45 PM revealed that "All Serious Reportable Incidents shall be investigated by the provider agency in which occurred, beginning within 12 hours after the incident was witnessed or discovered. Reportable incidents shall be investigated as required by internal agency policy, as determined by the provider agency's Incident Management Coordinator or in accordance with the District and/or Federal regulatory requirements." Further IMS revealed that "Incident Reports (to include all internal investigative documents) are to be maintained at the provider agency. Incident Reports for non reportable incidents shall be made available to all surveyors upon requests." [See W154] 3. The facility failed to implement the governing body's policy of tranportings clients. [See W186]	W 149	3. In future, the staff will be trained to properly monitor each client to maintain their safety. The QMRP will develop a protocol (Client to Client abuse) to prevent injuries for staff to adhere to after training. The QMRP will ensure that each injury is accompanied by immediate treatment by a licensed professional, an incident report generated, followed by notifications to various agencies and investigated accordingly. Cross Reference W186 6/25/07	6/25/07 & Ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of the investigative	W 153		

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G211	A. BUILDING _____ B. WING _____	05/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HRDI OF THE DISTRICT OF COLUMBIA, LLC	3073 VISTA STREET, NE WASHINGTON, DC 20018

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W 153	Continued From page 11 and incident reports and the review of the facility's Incident Management System (IMS), the facility failed to ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown origin were reported immediately to the administrator or to other officials as required by State Law [22 DCMR Chapter 35 - 3519.10] through established procedures for three of six clients residing in the facility. (Clients # 3, #4, and #6) The findings include: Review of the incident reports on 5/22/07 at 2:06 PM revealed the following incidents that had not been reported to the administrator according the facility's policy as evidence below: 1. On 5/14/07, Staff entered Client #3's room after she returned home from the day program and notice that she had scrapes on her left elbow and palm. Upon further observations when changing her, staff notice that she also had scrape marks on her knee. Interview with the facility's Registered Nurse on 5/22/07 at approximately 2:40 PM revealed that the nurse had assessed and cleaned the injuries. There was no evidence of a signature or date on the incident report indicating when the nurse cleaned the injuries. 2. On 4/30/07, the facility's driver witnessed Client #4 grabbing #3's face with her hands and scratching her. Staff reported that she stopped the van because she was the only staff and attended to it, but at this time, blood was already coming out form the scratch area. I had to proceed with the driving to pick up another staff for the van run. Three (3) scratches notice on the	W 153	1-7 The QMRP will ensure that each staff and the nurses are trained on the Incident Management Protocol and the administrator and the government agencies are notified within the specified timeframe. Each incident will be investigated and proactive strategies will be adopted to prevent such incidents from reoccurring. The QMRP will follow up on all client reported injuries. 6/30/07	6/30/07 & Ongoing

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W 153	Continued From page 12 right side of cheek. 3. On 4/3/07, staff helping Client #3 undress for shower when noticing a bruise on left should under her bra strap about the size of a nickel. According to the incident report, there was no evidence that a nurse had assessed the bruise and/or notified. 4. On 11/6/06, while preparing for a shower, staff notice a red circle on both thighs grape size marks, about one (1) inch long on Client #6. Etiology unknown. 5. On 10/4/06, Client #6 was transported to Providence Hospital via residential van. LPN assessed the client this morning during the medication pass as having swollen ankles and instructed staff to take her to the emergency room for further evaluation. 6. On 9/1/06, Client #6 was discovered by the day program staff to have a raised area on her forehead. Staff did not know how the injury occurred, therefore it is an injury of unknown origin. 7. A nursing progress note, dated 5/19/07, revealed that Client #4 sustained a bruise on the right arm. Interview with the Qualified Mental Retardation Professional (QMRP) on 5/22/07 at approximately 3:15 PM revealed the facility follows the Department on Disability Services (DDS) or (formally known as MRDDA) Incident Management Policies and Procedures. The QMRP stated that all injuries of unknown origin or injuries that's discovered, should be investigated.	W 153	P11-14 W153 1-7 The QMRP will ensure that each staff and the nurses are trained on the Incident Management Protocol and the administrator and the government agencies are notified within the specified timeframe. Each incident will be investigated and proactive strategies will be adopted to prevent such incidents from reoccurring. The QMRP will follow up on all client reported injuries. 6/30/07	6/30/07 & Ongoing

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W 153	Continued From page 13 On 5/23/07, the QMRP was asked for investigation reports for the aforementioned injuries of unknown origin listed above. On 5/24/07, the last day of the survey, the QMRP was able to produce one investigation for the incident on 9/1/06. It should be noted that the investigation report was completed by MRDDA Incident Management Investigation Unit. There no evidence of an internal investigation report, although the incident indicated that one was initiated on 9/1/06. Note: Review of the Qualified Mental Retardation Professional (QMRP) monthly notes were reviewed on 5/24/07 at approximately 9:00 AM. The month of April 2007 revealed Client #3 had no incidents; however, review of the unusual incidents report log book on 5/22/07 reflected three (3) incidents.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure all unusual incidences of injuries of unknown origin were thoroughly investigated. The findings include: Review of the facility's Unusual Incident Reports log book on 5/22/07 at 2:06 PM revealed the following incidents and/or injuries of unknown origin had not been investigated as evidence below:	W 154		

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W 154	Continued From page 14 1. On 5/14/07, Staff entered Client #3's room after she returned home from the day program and notice that she had scrapes on her left elbow and palm. Upon further observations when changing her, staff also notice that she also had scrape marks on her knee. There was no evidence that an investigation had been conducted to determine the cause of the injuries. 2. According to the facility's driver on 4/30/07, she witnessed Client #4 grabbing #3's face with her hands and scratching her while transporting the clients. "I stop the van because she was the only staff and attended to it, but at this time, blood was already coming out from the scratch area and I had to proceed with the driving to pick up another staff for the van run. Three (3) scratches notice on the right side of cheek". 3. On 4/3/07, staff helping Client #3 undress for shower noticed a bruise on left should under her bra strap about the size of a nickel. There is no evidence that the injury of unknown origin was investigated. 4. On 11/6/06, while preparing for a shower, staff notice a red circle on both thighs grape size marks, about one (1) inch long on Client #6. Etiology unknown. According to the incident report, the incident was investigated on 11/6/06; however, there is no evidence of an investigation report in the records. 5. On 10/4/06, Client #6 was transported to Providence Hospital via residential van. LPN assessed the client this morning during the medication pass as having swollen ankles and instructed staff to take her to the emergency room for further evaluation. According to the incident	W 154	P14-16 W154 1-7 The QMRP will be in-serviced to handle incidents according to HRDI policies and procedures. The facility's administrator and government agencies will be notified of each incident and investigated thereafter. In future, the QMRP will ensure that all copies of investigated incidents, internal or external, are maintained in each client's record for review when the need arises. 6/28/07	6/28/07 & Ongoing

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W 154	Continued From page 15 report, the incident was investigated; however, there is no evidence of an investigation report in the records. 6. On 9/1/06, Client #6 was discovered by the day program staff to have a raised area on her forehead. Staff did not know how the injury occurred, therefore it is an injury of unknown origin. An investigation report for this injury was given to the surveyor on the last day of the survey. This incident was investigated by the local agency; however, there was no evidence that the facility had conducted it's own internal investigation. 7. A nursing progress note, dated 5/19/07, revealed that Client #4 sustained a bruise on the right arm. There was no evidence that an investigation had been conducted to determine the cause of the injuries. Interview with the Qualified Mental Retardation Professional (QMRP) on 5/24/07 at approximately 11:00 AM revealed that the aforementioned incidents had been investigated; however, record review reflected no evidence that the injuries of unknown origin had been investigated.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported	W 156		

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W 156	Continued From page 16 to the administrator or designated representative with in five working days of the incident, for two of the six clients (Clients #2 and #5) that resided in the facility. The finding includes: Review of an unusual incident report on 5/22/07 at 2:06 PM revealed that Client #6 was discovered by the day program staff to have a raised area on her forehead. Staff did not know how the injury occurred. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the incident report on 5/24/07 at 10:45 AM revealed that the facility's initiated an internal investigation on 9/1/06. The QMRP submitted an investigation report initiated by MRDDA Incident Management and Investigations Unit (IMIU) to review. Review of the investigation report, dated 11/21/06 (2 months later), revealed that on 9/20/06, the IMIU received a "Serious Reportable Incident" completed by day program staff. According to the IMIU, the incident occurred on 9/1/06; however, the actual incident report form was submitted to the IMIU office on 9/20/06 (19 days later). There was no evidence that the results of the internal investigation was reported to the administrator.	W 156	P16-17 W156 In future, the QMRP and the Incident Management Coordinator will ensure that each investigated incident is reported to the administrator and other affiliated agencies within five (5) working days. 6/30/07 & Ongoing	6/30/07 & Ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility Qualified Mental Retardation	W 159		

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W 159	Continued From page 17 Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety. The findings include: 1. Clients #1, #2, #3 and #4 have several new consultants that started in January 2007. There was no evidence that the consultants who signed contracts had reviewed the needs of the clients or delivered any services to ensure that the actions of the staff in providing active treatment services were appropriate. The professional contracts were reviewed on May 24, 2007 at 12:50 PM. [See W234, W249, W255, and W257] 2. The QMRP failed to ensure that incident management policies and procedures were implemented to ensure the timely reporting and investigation of unusual incidents. [See W149] 3. The QMRP failed to ensure sufficient direct care staff to manage and supervise clients while being transported. [See W186] 4. The QMRP failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. [See W189] 5. The QMRP failed to ensure that clients who was receiving psychotropic medications had a psychiatric assessment . [See W212] 6. The QMRP failed to ensure program which incorporate restrictive techniques and use of behavior modification were conducted only with	W 159	P17-20 W159 1-11 The QMRP will be in-serviced by the Program Director on the policies regarding provision of clients' needs and services in a timely manner. The QMRP will be trained to properly monitor, integrate and coordinate each client's health and safety. 1. Cross Reference W 234 Cross Reference W249 Cross Reference W255 Cross Reference W257 2. Cross Reference W149 3. Cross Reference W186 4. Cross Reference W189 5. Cross Reference W212 6. Cross Reference W262 and W263	6/28/07 & Ongoing

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W 159	Continued From page 18 written informed consent. [See W262 and W263] 7. The QMRP failed to ensure that the clients recommended equipment had been maintained and functional for use. [See W436] 8. Following the dinner meal observed on May 22, 2007 at approximately 6:20 PM, client #2 was observed to put saliva and chewed food particles in her hand and rub it across her hair and on others who may have been in her immediate surroundings. Client #2 was blind and her actions did not appear to be targeted at any one person. There was no behavioral support plan on file. After being informed that a plan was not located in the file, neither the QMRP nor the House Manager could locate a copy of the Behavioral Support Plan (BSP). A review of clinical records was conducted on May 24, 2007 at 12:35 PM, and a document that reflected "BSP review" dated April 20, 2005 was identified. The document reflected that the plan was to address self stimulation behaviors. "The strategies described in the BSP of April 2004 continues to appropriately address these strategies will remain in place." It could not be determined that Client #2's BSP plan had been reviewed in two years. There was no BSP available during the survey period. Interviews on May 22, 2007 with day program and facility direct care staff, revealed that the Client's behaviors of wetting her hand and putting the elements over her face and head continues to occur. According to the staff, they were not provided directions to address the behaviors. According to the documentation reviewed on May 23, 2007 at 4:55 PM, client #2 had exhibited the	W 159	7. Cross Reference W436 8. The QMRP will in future follow up with the Psychologist regarding inappropriate behaviors manifested by Client #2. A Behavior Support Plan is in place to address Client #2's behaviors. 7/02/07	7/02/07 & Ongoing

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W 159	Continued From page 19 behavior 21 times from May 1 to May 22, 2007. 9. Refer to W255 and W257. The QMRP failed to ensure consistent opporutnities for clients to learn and enhance skills. 10. Refer to W249. The QMRP failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). 10. The Qualified Mental Retardation Professional (QMRP) failed to ensure that training programs included methodology for staff implementation. Refer to W234	W 159	9. Cross Reference W255 and W257 10. Cross Reference W249 11. Cross Reference W234	
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure sufficient direct care staff to manage and supervise clients while being transported for two of four clients residing in the facility. (Client #3 and #4) The finding includes: The facility failed to implemented their facility's policy on transporting clients as evidence below: Review of the incident reports on 5/22/07 at 2:06	W 186		

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W 186	Continued From page 20 PM revealed an incident dated 4/30/07. According to the incident report, "the facility's driver witnessed Client #4 grabbing #3's face with her hands and scratching her. Staff reported that she stopped the van because she was the only staff and attended to it, but at this time, blood was already coming out form the scratch area. I had to proceed with the driving to pick up another staff for the van run. Three (3) scratches notice on the right side of cheek." Interview with the House Manager and Qualified Mental Retardation Professional (QMRP) on 5/23/07 at approximately 2:00 PM, revealed that at least "two" staff members should be on the van at all times. Further interview with the House Manager revealed that they were in the process of hiring more staff to prevent a shortage in transporting the clients. The facility's "Client Transportation Policy" reviewed on 5/24/07 at approximately 11:00 PM revealed that, "If a staff member is transporting a client, there must be an aid on the vehicle in addition to the driver."	W 186	P20-21 W186 The QMRP will ensure consistent and adequate staff coverage at home and during transportation of each client per HRDI policies and procedures. This coordination will be done in conjunction with the Human Resources Department. In future, the QMRP and House Manager will ensure client safety by having two staff on the van during client transportation. 6/28/07	6/28/07 & Ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and	W 189		

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W 189	Continued From page 21 competently. The finding includes: 1. Observations of the the dinner meal conducted on 5/22/07 beginning at 6:24 PM revealed Client #3 eating her dinner meal very rapidly while staff supervised the table. Interview with the staff #1 on the same day at approximately 7:15 PM indicated that Client #3 eats very fast and has to be prompted to slow down. Review of the Speech and Language Assessment dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that three staff had been trained on aspiration on 5/17/06. There was no evidence that training had been provided for the staff observed and there was no current training documented. 2. There was no evidence of staff training for communications programs. Refer to W249 3. There was no evidence of staff training for clients behavioral support plans. Refer to W249 4. There was no evidence of staff training for use	W 189	P21-23 W189 1.The Nurse will train staff on Aspiration Protocol regarding Client #3. 6/30/07 2. Cross Reference W249 3. Cross Reference W249 4. Cross Reference W249 and W436 5. Cross Reference W342	6/30/07 & Ongoing

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W 189	Continued From page 22 of recommended equipments for clients needing sensory motor devices. Refer to W249 and W436. 5. The facility failed to ensure staff training on clients medical diagnosis. Refer to W342	W 189		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure that one of three clients in the sample who was receiving psychotropic medications had a psychiatric assessment (Client #3); and failed to ensure that one focus client (Clients #4) who were receiving psychotropic medications had a psychiatric assessment. The findings include: 1. Observation of the evening medication administration conducted on 5/22/07 at beginning at 4:50 PM, revealed Client #3 received Risperdal 1 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 4:57 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 8:49 AM revealed that Risperdal 1 mg by mouth QPM was incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head rubbing, self-harm, and uncooperativeness. Review of Client #3's	W 212	P23-24 W212 1 & 2 The QMRP will ensure that each client prescribed psychotropic medications has a psychiatric evaluation in place. The psychiatrist has evaluated Clients #3 and #4 for restrictive medications being administered. 7/03/07	7/3/07 & Ongoing

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W 212	Continued From page 23 medical records on 5/23/07 at 8:49 PM revealed that the psychotropic medications was prescribed to address behaviors associated Depression Disorder with Psychotic features and Behavioral Disorder. Further review of the medical records on the same day at approximately 9:15 AM, revealed no documented evidence of a psychiatric assessment. 2. Observation of the evening medication administration conducted on 5/22/07 at approximately 5:31 PM, revealed Client #4 received Buspar 15 mg, Risperdal 2 mg, Tegretol 200 mg, and Revia 30 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 4:57 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 10:16 AM revealed that the psychotropic medications were incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head banging and self injurious behaviors. Review of Client #4's medical records on 5/23/07 at approximately 10:16 AM, revealed no documented evidence of a psychiatric assessment.	W 212	P23-24 W212 1 & 2 The QMRP will ensure that each client prescribed psychotropic medications has a psychiatric evaluation in place. The psychiatrist has evaluated Clients #3 and #4 for restrictive medications being administered. 7/03/07	7/3/07 & Ongoing
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on the review of records, the	W 227		

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W 227	Continued From page 24 Interdisciplinary Team failed to ensure that the social worker's recommendation had been developed into an objective and implemented to address the identified need of client #1 in the sample. The findings include: On May 23, 2007 at approximately 11:10 AM, client #1's social work assessment dated January 4, 2007 was reviewed. The assessment reflected that client #1 had a need to enhance her social skills. The social worker recommended a socialization program. The program involved the client passing items to her peers during family style meals. The recommendation had not been established as an objective as of this survey and no documentation was available to determine that the recommendation had been implemented.	W 227	P24-25 W227 The QMRP has developed a program for Client #1 to enhance her socialization skills. Staff will be trained by the QMRP to properly implement this goal/objective as outlined. 7/01/07	7/1/07 & Ongoing
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on the review of individual program plans (IPP), the Qualified Mental Retardation Professional (QMRP) failed to ensure that training programs included methodology for staff implementation. The findings include: Client #1's IPPs were reviewed on May 23, 2007 at approximately 11:25 AM.	W 234		

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W 234	Continued From page 25 The following IPP's did not include the written instuctions for the direct care staff to implement these objectives with consistentcy. Client will brush her teeth with 100% verbal prompting, Client will lotion self with verbal assistance eight consecutive sessions, Client will purchase an item on a community outing with visual cues.	W 234	P25 W234 The Program Director will train the QMRP to provide staff with skill acquisition programs to assist the staff to properly implement each program. 7/03/07 & Ongoing	7/3/07 & Ongoing
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). The findings include: 1. Client #2's IPPs, documentation, and clinical records were reviewed on May 24, 2007 at 11:40 AM. According to client #2's IPP, the client had a	W 249	P26-28 W249 1&2 The QMRP will train staff to implement programs and interact with clients as indicated on the data sheets. Client #2 will be given the opportunity to enhance her skills through ongoing engagement in activities. 6/30/07	6/30/07 & Ongoing

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W 249	Continued From page 26 program that read "will improve expressive language skills by using the sign eat for 80% of the opportunities with hand/hand. Observations of snack times were made on May 22, and 23, 2007 at approximately 4:15 PM each day and a dinner meal on May 22, 2007 at approximately 6:10 PM. There were no attempts observed to have client #2 to sign eat at the given opportunities. 2. During the observation period on May 22, 2007, client #2 was observed to be visually impaired. The House Manager confirmed that client #2 was blind. This diagnosis was also included on the Medical assessment dated January 23, 2007 that was reviewed on May 22, 2007 at 6:00 PM. The psychological assessment dated January 2007 that was reviewed on May 23, 2007 at 3:45 PM reflected that the client should be encouraged to participate in sensory activities including sound, smell, tast, and touch. Further stated was the "it would be helpful to tailor activities around her senses". On May 23, 2007 at 4:03 AM, the House Manager indicated that sensory motor equipment was in the facility. The equipment shown included a sensi- ball switch, vibrating mini bubbles, gooshy switch, oval tax multi sensory, and high music vibration enabling device. These items were inoperable perhaps due to having no batteries. Although music played while all clients were sitting out on their porch, this was the only sensory motor functioning activity provided during the observation. It could not be determined that client #2 had been engaged in the multiple	W 249	P26-28 W249 1&2 The QMRP will train staff to implement programs and interact with clients as indicated on the data sheets. Client #2 will be given the opportunity to enhance her skills through ongoing engagement in activities. 6/30/07	6/30/07 & Ongoing

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W 249	Continued From page 27 sensory task/activities as recommended. 3. Client #2's IPP and data was reviewed on May 24, 2007 at approximately 11:00 AM. a. Client #2 had an objective which read "will participate in an activity with her peers or staff with verbal assistance". The focus of the program was identified to be "setting the table". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007. The documentation that was reviewed reflected that the client had performed at 0% since January 2007. b. Client #2's had an objective to "stack utensils on top of her plate ". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007.	W 249	P28 W249 conts 3 a & b Staff will be trained to assist clients by providing opportunities for each client to perform tasks that will enhance their skills. 7/03/07	7/3/07 & Ongoing
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs)as they had been successfully achieved for one (#1) of four clients in the sample.	W 255		

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W 255	Continued From page 28 The findings include: IPPs and related data collection was reviewed on May 23, 2007 at 11:10 AM. There were no revisions made to programs that had been achieved at the stated criterion level as reflected below. a. Client #1's IPP indicated that the client would complete task with peers using verbal assistance on 4/4/ trials. The documentation reflected that from January 2007 to April 2007, the client performed at 100% verbal prompting thus meeting the criterion level. b. Client #1's financial IPP read that the client would purchase an item on a community outing with visual cues. According to the documentation reviewed, the client performed with 100% verbal prompting from January 2007 to May 2007. Interviews with the direct care staff at the facility interviewed on May 22, 2007 at 5:20 PM and with the direct care staff at the day program on May 22, 2007 at 11:20 AM, client #1 performs purchasing task with verbal prompting coupled with gestures for the actual purchasing exchange. It could not be determined that client #1 had continued to be challeged in her goal areas.	W 255	P28-29 W255 a & b The QMRP will be trained to monitor and review Client #1's program plan and modify, discontinue or revise programs when achieved per criterion outlined. 6/28/07 & Ongoing	6/28/07 & Ongoing
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.	W 257		

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W 257	Continued From page 29 This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs) that had not been achieved by clients #1 and #2. The findings include: 1. Client #1's IPPs and documentation was reviewed on May 23, 2007 at 11:10 AM. Revisions had not been made to programs that had not been mastered based on the criterion levels. Client #1 had an IPP to brush her teeth with 100% verbal prompting. The documentation reviewed for this program reflected that the client had not met criterion and performed only 66% of the time with verbal prompting, from January 2007 to May 2007. The remaining trials were conducted with physical prompting and 1% independence. There were no revisions to the IPP or objective to encourage the client's success. 2. Client #2's IPPs, documentation, and clinical records were reviewed on May 24, 2007 between 11:40 AM and 12:30 PM. There were no revisions made to programs that had not been mastered based on the stated criterion levels. According to client #2's IPP, the client had a program that read "will improve expressive language skills by using the sign eat in 80% of the opportunities with hand/hand. The IPP was dated to have started in January 2007; however, review of the speech section of the clinical chart, it was	W 257	P29-32 W257 1-3 In future, the QMRP will revise programs that have been achieved for Clients #1 and #2. The QMRP will indicate in future, in monthly notes, the status of each goal/objective as outlined. The QMRP will maintain accurate documentation of each program status. 6/28/07 & Ongoing	6/28/07 & Ongoing

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W 257	Continued From page 30 determined that the IPP for signing eat was initiated in February 2006 with. There were no changes to the objective since that time. The speech assessment dated October 18, 2006 reflected "continue with her communications program as she demonstrates growth, more basic signs will be added." The documentation reflected that from December 2006 to March 2007 trials were refuses 100% of the trials. April 2007's data reflected 40% hand over hand and 60% refusal, and May 2007 had been recorded at 100% refusals. Although the client continued to unachieve the criterion, there were no revisions to the IPP or the objective. 3. Client #2 had a program which read "will participate in an activity with her peers or staff with verbal assistance". The focus of the program was identified to be "setting the table". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007. The documentation reviewed reflected that the client performed at 0% from January 2007 to March 2007. It should be mentioned that the documentation reflected that client #2 progressed at 100% in April and May 2007. Inquiry was made to the QMRP as to what took place for such change in performance. There had been no changes made to the program or objective. The QMRP did not elaborate as to what may have precipitated this increased achievement. There evidence did not support that client #2's	W 257	P29-32 W257 1-3 In future, the QMRP will revise programs that have been achieved for Clients #1 and #2. The QMRP will indicate in future, in monthly notes, the status of each goal/objective as outlined. The QMRP will maintain accurate documentation of each program status. 6/28/07 & Ongoing	6/28/07 & Ongoing

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W 257	Continued From page 31 program had been revised to encourage the client's success in the mastery of this objective.	W 257		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on review of clients individual program plans (IPPs), the interdisciplinary team (IDT) failed to make revision or to justify the repetition of the objectives from the previous year. The findings include: Client #1's assessments, IPPs and documentation were reviewed on May 23, 2007 at 11:10 AM. The IPPs identified in client #1's individual support plan (ISP)dated January 2007 were continued from the previous ISP annual. The Occupation Therapy assessment that was reviewed was dated January 30 2006. The recommendations included objectives for toothbrushing, applying lotion, making a store purchase, and completing a task with peers. The assessment further reflected that "these programs are performed on a routine basis and should be continued". The written IPPs reflected that these program criterions and objectives were not revised during the January 2007 individual support plan meeting.	W 260	P32 W260 The QMRP as the facilitator of an ISP will ensure that in future, a repeated program objective from a previous year is justified in the ISP. The QMRP will ensure that each service or need provided to each client is justified. 6/28/07	6/28/07 & Ongoing
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE	W 262	P33 W262 Cross Reference W124	

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W 262	Continued From page 32 The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Human Rights Committee (HRC) failed to review, approve, and monitor the use of psychotropic medications to manage inappropriate behaviors for one of three clients included in the sample. (Client #3) The finding includes: According to the Human Rights Committee (HRC) Policy reviewed on 5/23/07 at approximately 2:30 PM, "the role of the HRC is to monitor and assure the rights and dignity of all clients served by the facility. The HRC shall review and monitor aversive behavior modification programs, research, experimentation, medications used as restraints, and medications used as behavior modifiers". There was no evidence that the HRC reviewed and monitored Client #3's psychotropic medication and other behavioral support interventions to included the behavior support plan and the use of psychotropic medication and behavioral intervention techniques employed by the direct care staff. The facility failed to evidence HRC minutes which included the review/acceptance/approval. (See W124)	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs	W 263		

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W 263	Continued From page 33 are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents, for two of four clients residing in the facility. (Client #3 and #4) The findings includes: The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Client #3 and #4's Behavior Support Plan (BSP) in conjunction with the use of prescribed psychotropic medications as evidenced below. 1. There was no evidence that written consent had been obtained for Client #3's Behavior Support Plan (BSP) which included prescribed psychotropic medication. Interview with Qualified Mental Retardation Professional (QMRP) on 5/22/07 at approximately 2:35 PM revealed that Client #3 did not have written informed consent signed by a guardian or any other person identified as responsible at the time of the survey; however, the QMRP has submitted paper to obtain guardianship for the client. [See W124] 2. There was no evidence that written consent had been obtained for Client #4's Behavior Support Plan (BSP) which included prescribed psychotropic medication. Interview with Qualified Mental Retardation Professional (QMRP) on	W 263	P33-35 W263 1. The Human Rights Committee will continue to review recommended psychotropic medications to approve or disapprove accordingly until a sanctioned legal guardian is appointed by the court. The QMRP and the MRDDA Case Manager will continue to work to get a legally appointed guardian for Client #3. Cross Reference W124 2. Cross Reference W124 6/28/07 & Ongoing	6/28/07 & Ongoing

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W 263	Continued From page 34 5/22/07 at approximately 2:35 PM revealed that Client #4 did not have written informed consent signed by a guardian or any other person identified as responsible at the time of the survey; however, the QMRP has submitted paper to obtain guardianship for the client. [See W124]	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample. The finding includes: 1. On May 22, 2007, between 2:05 PM and 4:00 PM, client #1's medical records were reviewed. The medical assessment dated September 19, 2006 reflected the following medical recommendation procedures were not completed timely as evidence below: a. According to a GYN consultation dated July 11, 2006, client #1 allowed a small sample obtained for the culture since the client "did not allow brushing of the cervix". The document reflected that if the sample was not adequate then the procedure would need to be repeated. Prior to this examination, another exam had been attempted March 2005; however, it was unsuccessful. The primary physician's note dated August 16, 2006 reviewed at 3:48 PM reflected "annual exam, pap done, results pending". At the	W 322	P35-39 W 322 1. a & d The results for Client #1s GYN and EKG have been obtained and in future, the RN and the nursing team in collaboration with the QMRP will ensure that her results are obtained in a timely manner. 6/25/07	6/25/07 & Ongoing

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W 322	Continued From page 35 time of the survey, the result were not available and the physician had not made further reference to the results in follow up monthly notes. b. According to client #1's mammogram report dated March 27, 2006, the client was to have a return visit in twelve months. At the time of the survey, the annual mammogram had not been done. The surveyor the Registered Nurse (RN) discussed the appointment. On May 24, 2007, at 11:30 AM, the RN informed the surveyor that client #1 was not seen at the time that the other clients received their mammograms because the LPN was told that client #1 required a diagnostic mammogram. The RN scheduled the exam at the time of survey for June 11, 2007. The facility failed to ensure that client #1 received a timely diagnostic mammogram as recommended. It should be mentioned that the facility medical staff conducts quarterly breast examinations and documents the findings. c. According to client #1's ENT report reviewed at 3:55 PM, client #1 was seen August 7, 2006 and had the right ear wax removed and the left ear wax was partially removed. Debrox for the left ear wax prescribed for one month prior to follow up. There were further instructions to follow up in six months to one year and then have the audiological performed. Client #1 was seen by the audiologist for a (Brainstem Response) BSER on October 31, 2006. The client was diagnosed with excessive cerumen in the left ear. The facility was requested to not return the client until the ears are cleared. The nursing staff failed to follow through on the	W 322	1. b & c Client #1 has been scheduled for Mammogram and BSER follow up as indicated. In future, the RN, nursing team and QMRP will ensure that appropriate medical follow up is done for the client. 6/15/07	6/15/07 & Ongoing

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W 322	Continued From page 36 ENT return visit recommendations prior to attempting the BSER. d. According to the primary physician's notation on an August 7, 2006's consultation document, client #1 had a diagnosis of hypertension. Also noted by the primary physician was that client #1 had an EKG conducted and that the report was to follow. The surveyor and the RN attempted to locate the results of the EKG on May 25, 2007 at 11:53 AM. The report was not available at the facility. There were no follow up notations about the EKG identified in the following months of summaries by the primary physician. 2. The facility failed to provide safe techniques to encourage clients #1 and #3 from consuming foods in a fast pace. a). Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed all of her food. There was no intervention observed or overheard. An interview with client #1's lead day program staff was conducted on May 22, 2007 at 11:20 AM. This interview revealed that client #1 was capable of eating independently; however, the client was monitored to slow down. The client was also prescribed a chopped diet. On May 23, 2007 at approximately 9:00 AM, the surveyor inquired as to rather client #1 had any guidelines for eating as part of her meal plan. A speech report dated November 13, 2006 was	W 322	P35-39 W 322 1. a & d The results for Client #1s GYN and EKG have been obtained and in future, the RN and the nursing team in collaboration with the QMRP will ensure that her results are obtained in a timely manner. 6/25/07 W322 2 a & b The QMRP will ensure that the staff is retrained on Aspiration for Clients #1 and #3. Periodic mealtime observations will be made by the QMRP to ensure proper staff assistance of clients at mealtime. 6/28/07	6/25/07 & Ongoing 6/28/07 & Ongoing

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W 322	Continued From page 37 reviewed on May 23, 2006 at 9:00 AM. This report reflected "home should continue to use guidelines to promote slow eating rate". Another report noted by speech and dated June 8, 2006 reflected "follow eating and texture guidelines per the speech therapist. A document identified in client #1's training book reflected "pace by using attached slow eating rate protocol". There was no attached protocol. It could not be determined that client #1's rapid eating pace had been addressed through a formal and consistent protocol to prevent possible choking. b). During observations of the the dinner meal conducted on May 22, 2007 beginning at 6:24 PM, Client #3 was observed eating her dinner meal. The client was observed eating very rapidly while staff supervised the table. Interview with the staff #1 on the same day at approximately 7:15 PM indicated that Client #3 eats very fast and has to be prompted to slow down. Review of the Speech and Language Assessment dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was	W 322	b The QMRP will ensure that the staff is retrained on Aspiration for Clients #1 and #3. Periodic mealtime observations will be made by the QMRP to ensure proper staff assistance of clients at mealtime. 6/28/07	6/28/07 & Ongoing

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W 322	Continued From page 38 no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist. Note: The medical assessment date September 19, 2006 reflected diagnoses to include hypertension and history of carcinoma of left breast, left breast mastectomy.	W 322		
W 342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on observation, interviews, and the review of training records the facility's nursing services failed to ensure that the direct care staff had been provided training in detecting signs and symptoms of illness or dysfunction for one of four clients in the sample. The finding includes: Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed all of her food. There was no intervention observed or overheard.	W 342	P39-40 W342 The RN and/or LPN will train the direct care staff on signs and symptoms of aspiration. The QMRP will follow up with periodic observation at mealtimes to ensure that prompt Client #1 to slow down her eating pace to prevent choking. 7/01/07	7/01/07 & Ongoing

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W 342	Continued From page 39 Based on staff performance during the dinner meal, it could not be determined that the direct care staff, overseeing client #1's meal, had been trained to address client #1's rapid eating pace and potential for aspiration. The training record reviewed on May 24, 2007 at approximately 11:30 PM reflected that out of nine direct care staff three direct care staff had received training on May 17, 2006 on detection of signs and symptoms of aspiration. There were no current trained direct care staff.	W 342		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that clients were provided with necessary adaptive equipment, for two of four clients included in the sample. (Client #2, #4) The findings include: The facility failed to ensure that Clients#2 and #4 stimulation tools was maintained and in good repair. 1. Observations and attempts to interview the Client#4 revealed that the client was non verbal. Review of Client #4's habilitation records on	W 436	P40-41 W436 1. The QMRP and the House Manager check the equipment used on a monthly basis to ensure that Client #4 has her stimulating tools. The QMRP will ensure that batteries are purchased for the items to make them functional at all times. 6/28/07 & Ongoing	6/28/07 & Ongoing

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W 436	Continued From page 40 5/24/07 at approximately 3:50 PM revealed Psychological Assessment dated 11/30/06. The assessment documented that given the following recommendations, "Promote use of sensory stimulations tools and exploration of her environment through touch and smell". Interview with the House Manager on 5/23/06 at 4:03 PM revealed that Client #4 has several sensory stimulations tools. When asked to see the stimulation tools, the house manager presented the surveyor with a sensi- ball switch, vibrating mini bubbles, the gooshy switch, oval tax multi sensory, and high music vibration enabling device all of which required batteries. Further interview with the house manager revealed that tools have been without operating batteries for over a month. Therefore, the stimulation tools was not available for the client's use. 2. The facility failed to provide client #2 with functional sensory stimulation equipment. Refer to W249.	W 436	2. Cross Reference W249	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 5/22/07 at 3:15PM revealed the scheduled shifts are as follows:	W 440		

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W 440	Continued From page 41 Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM - 4 PM to 10 PM 3rd Shift 10 PM to 6 AM Review of the fire drill log for April 2007 through to February 2007 revealed that the facility failed to hold fire evacuation drills for all shifts on a quarterly basis. Drills were not conducted on the third shift.	W 440	P41-42 W440 The QMRP will ensure that each shift conducts one fire drill a month. The QMRP and the House Manager will develop a system to remind them of each drill to be conducted. Staff training will be done to ensure compliance with drills on all shifts. 6/28/07	6/28/07 & Ongoing

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I 000	INITIAL COMMENTS This licensure survey was conducted from May 22, through May 24, 2007. A random sample of three clients was initially selected from a residential population of six females. An additional client was added to the sample as a focus. All clients in the sample had diagnoses of profound mental retardation. Two of the clients had diagnosis of blindness and three clients had psychiatric diagnoses for which medications were prescribed. The consumers in this facility had limited to no skills in verbal communications. The findings of this survey based on observations at the facility and day programs ,staff interviews at both the facility and day programs, review of clinical, medical, and administrative records to include the facility's unusual incident reports and policies.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: The findings include: Review of Resident #3's physician's orders dated 4/1/07 and annual nutritional evaluation dated 12/8/06 revealed that she was prescribed a Low-fat, Low Cholesterol 1500 calorie diet, finely chopped. Further record review failed to show evidence that a dietitian or nutritionist had reviewed her diet plan at least quarterly.	I 043	P1 1043 The QMRP will review Client #3's record on a monthly basis and ensure that the Nutritionist has reviewed the records as indicated on a quarterly basis. 6/28/07	6/28/07 & Ongoing
I 052	3502.10 MEAL SERVICE / DINING AREAS	I 052		

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I 052	Continued From page 1 Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: The findings include: During the dinner observation conducted on May 22, 2007 at approximately 6:20 PM, all clients were provided with spoons to eat with. There was no encouragement for clients to utilize other utensils as appropriate. Clients #1 and #2's habilitation reports did not reflect that these clients were incapable of using or learning to use utensils other than spoons.	I 052	P1-2 1052 The staff and QMRP will encourage Clients #1 and #2 to use other cutlery at mealtimes. The QMRP will ensure that the table is set with these items for the clients to learn how to use them. 6/28/07	6/28/07 & Ongoing
I 055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils. This Statute is not met as evidenced by: The findings include: 1. The facility failed to provide safe techniques to encourage client #1 from consuming foods in a fast pace. Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed all of her food. There was no intervention observed or overheard.	I 055	P2-4 1055 1-2 The QMRP will ensure through periodic mealtime observation that the staff provide interventions that will promote client safety to client #1 and #3. The QMRP will follow up on all the necessary protocols and train staff to adhere to recommendations made by Professional staff at all times. 7/03/07	7/03/07 & Ongoing

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I 055	Continued From page 2 An interview with client #1's lead day program staff was conducted on May 22, 2007 at 11:20 AM. This interview revealed that client #1 was capable of eating independently; however, the client was monitored to slow down. The client was also prescribed a chopped diet. On May 23, 2007 at approximately 9:00 AM, the surveyor inquired as to rather client #1 had any guidelines for eating as part of her meal plan. A speech report dated November 13, 2006 was reviewed on May 23, 2006 at 9:00 AM. This report reflected "home should continue to use guidelines to promote slow eating rate". Another report noted by speech and dated June 8, 2006 reflected "follow eating and texture guidelines per the speech therapist. A document identified in client #1's training book reflected "pace by using attached slow eating rate protocol". There was no attached protocol. The GHMR failed to demonstrate that staff had been trained in the use of proper feeding techniques to assist residents who required special feeding procedures or utensils. 2. During observations of the the dinner meal conducted on May 22, 2007 beginning at 6:24 PM, Client #3 was observed eating her dinner meal. The client was observed eating very rapidly while staff supervised the table. Interview with the staff #1 on the same day at approximately 7:15 PM indicated that Client #3 eats very fast and has to be prompted to slow down. Review of the Speech and Language Assessment dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The	I 055	P2-4 1055 1-2 The QMRP will ensure through periodic mealtime observation that the staff provide interventions that will promote client safety to client #1 and #3. The QMRP will follow up on all the necessary protocols and train staff to adhere to recommendations made by Professional staff at all times. 7/03/07	7/03/07 & Ongoing

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I 055	Continued From page 3 protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist.	I 055		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The findings include: During the environmental inspection on May 24, 2007 at 9:35 AM, the surveyor recognized that excessive molding was found on the window ceil and around the window casing of the second floor bathroom.	I 090	P4 1090 The window sill has been cleaned and in future, the QMRP and House Manager will conduct monthly environmental check to ensure that the facility is clean. The Maintenance team will be called to repair any items that need attention. 6/28/07	6/28/07 & Ongoing
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least	I 135		

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I 135	Continued From page 4 four (4) times a year for each shift. This Statute is not met as evidenced by: The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 5/22/07 at 3:15PM revealed the scheduled shifts are as follows: Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM - 4 PM to 10 PM 3rd Shift 10 PM to 6 AM Review of the fire drill log for April 2007 through to February 2007 revealed that the facility failed to hold fire evacuation drills for all shifts on a quarterly basis. Drills were not conducted on the third shift.	I 135	P4-5 1135 The QMRP will ensure that each shift conducts one fire drill a month. The QMRP and the House Manager will develop a system to remind them of each drill to be conducted. Staff training will be done to ensure compliance with drills on all shifts. 6/28/07 & Ongoing	6/28/07 & Ongoing
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: The findings include: Personnel records reviewed on May 24, 2007 at 9:50 AM revealed that seven out of ten staff to include the House Manager did not contain current signed job descriptions.	I 203	The Human Resources Department in collaboration with the QMRP will ensure that each employee working in the facility has a signed job description. 7/10/07	7/10/07 & Ongoing
I 206	3509.6 PERSONNEL POLICIES	I 206		

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I 206	Continued From page 5 Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: The findings include: Personnel records reviewed on May 24, 2007 at 9:50 AM revealed that three staff listed by the weekly schedule did not have files available for review including current health certificates. Two of the staff did not have availabe PPD testing or x-ray. The finding includes: Review of the personnel files on 5/24/07, the GHMRP failed to provide current health certification for the following consultants: (C1), (C4), and (C5).	I 206	P5-6 1206 The Human Resources Department in collaboration with the QMRP will ensure that each employee or Professional staff has a current PPD and health certificate. 7/10/07	7/10/07 & Ongoing
I 209	3509.9(a) PERSONNEL POLICIES Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (a) Child or resident abuse or abuse of someone under his or her care and supervision; This Statute is not met as evidenced by: The findings include:	I 209		

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I 209	Continued From page 6 Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not containe police clearences.	I 209	P6-7 1209 The Human Resources Department in collaboration with the QMRP will ensure that each employee has a current file with police clearances for review as it pertains to abuse. 7/10/07	
I 210	3509.9(b) PERSONNEL POLICIES Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (b) Neglect; This Statute is not met as evidenced by: The findings include: Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not containe police clearences.	I 210	1210 The Human Resources Department in collaboration with the QMRP will ensure that each employee has a current file with police clearances for review as it pertains to neglect. 7/10/07	7/10/07 & Ongoing 7/10/07 & Ongoing
I 211	3509.9(c) PERSONNEL POLICIES Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (c) Exploitation; or... This Statute is not met as evidenced by: The findings include: Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not contain police clearences.	I 211	1211 The Human Resources Department in collaboration with the QMRP will ensure that each employee has a current file with police clearances for review as it pertains to Exploitation. 7/10/07	7/10/07 & Ongoing

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I 212	3509.9(d) PERSONNEL POLICIES Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following: (d) Conviction for a sexual offense or violent crime. This Statute is not met as evidenced by: The findings include: Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not containe police clearences.	I 212	P8 1212 The Human Resources Department in collaboration with the QMRP will ensure that each employee has a current file with police clearances for review as it pertains to sexual or violent crime conviction. 7/10/07	7/10/07 & Ongoing
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: The finding includes: [See Federal Deficiency Report Citation W189]	I 222	P8 1222 Cross Reference W189	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall	I 379		

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I 379	Continued From page 8 be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: The findings includes: Review of the unusual incident reports conducted on 5/2207 at 2:06 PM revealed that the following incidents had not been reported to the Department of Health within 24 hours as evidence below: 1. On 5/14/07, Staff entered Client #3's room after she returned home from the day program and notice that she had scrapes on her left elbow and palm. Upon further observations when changing her, staff notice that she also had scrape marks on her knee. Interview with the facility's Registered Nurse on 5/22/07 at approximately 2:40 PM revealed that the nurse had assessed and cleaned the injuries. There was no evidence of a signature or date on the incident report indicating when the nurse cleaned the injuries. 2. On 4/30/07, the facility's driver witnessed Client #4 grabbing #3's face with her hands and scratching her. Staff reported that she stopped the van because she was the only staff and attended to it, but at this time, blood was already coming out form the scratch area. I had to proceed with the driving to pick up another staff for the van run. Three (3) scratches notice on the right side of cheek. 3. On 4/3/07, staff helping Client #3 undress for shower when noticing a bruise on left should	I 379	P8-10 1379 1-7 The QMRP will ensure that all Serious Reportable incidents are reported to the government within 24 hours. The QMRP will also ensure that staff complete these incidents properly providing pertinent information in the areas provided to facilitate the investigative process. 6/28/07	6/28/07 & Ongoing

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I 379	Continued From page 9 under her bra strap about the size of a nickel. According to the incident report, there was no evidence that a nurse had assessed the bruise and/or notified. 4. On 11/6/06, while preparing for a shower, staff notice a red circle on both thighs grape size marks, about one (1) inch long. Etiology unknown. 5. On 10/4/06, Client #6 was transported to Providence Hospital via residential van. LPN assessed the client this morning during the medication pass as having swollen ankles and instructed staff to take her to the emergency room for further evaluation. 6. On 9/1/06, discovered by the day program staff to have a raised area on her forehead. Staff did not know how the injury occurred, therefore it is an injury of unknown origin. 7. A nursing progress note, dated 5/19/07, revealed that Client #4 sustained a bruise on the right arm. 8. See also Federal Deficiency Report - W149, W153, W154, and W156	I 379	P8-10 1379 1-7 The QMRP will ensure that all Serious Reportable incidents are reported to the government within 24 hours. The QMRP will also ensure that staff complete these incidents properly providing pertinent information in the areas provided to facilitate the investigative process. 6/28/07 8. Cross Reference W149, W153, W154 and W156.	6/28/07 & Ongoing
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals	I 391		

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I 391	Continued From page 10 trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: The findings: 1. On May 22, 2007, between 2:05 PM and 4:00 PM, client #1's medical records were reviewed. The medical assessment date September 19, 2006 reflected diagnoses to include hypertension and history of carcinoma of left breast, left breast mastectomy. a. According to a GYN consultation dated July 11, 2006, client #1 allowed a small sample obtained for the culture since the client "did not allow brushing of the cervix". The document reflected that if the sample was not adequate then the procedure would need to be repeated. Prior to this examination, another exam had been attempted March 2005; however, it was unsuccessful. The primary physician's note dated August 16, 2006 reviewed at 3:48 PM reflected "annual exam, pap done, results pending". At the time of the survey, the result were not available and the physician had not made further reference to the results in follow up monthly notes. b. According to client #1's mammogram report dated March 27, 2006, the client was to have a return visit in twelve months. At the time of the survey, the annual mammogram had not been done. The surveyor and Registered Nurse (RN) discussed the appointment. On May 24, 2007, at 11:30 AM, the RN informed the surveyor that client #1 was not seen at the time that the other	I 391	P10-14 1391 1. a-d The RN, the Nursing team and the QMRP will ensure that the all client related medical services are obtained in a timely manner. The RN will ensure that diagnostic results are obtained and medical follow for each individual is done in a timely manner. The Nurses will maintain a medical diary to track all medical appointments and necessary follow up. 7/03/07	7/03/07 & Ongoing

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I 391	Continued From page 11 clients received their mammograms because the LPN was told that client #1 required a diagnostic mammogram. The RN scheduled the exam at the time of survey for June 11, 2007. The facility failed to ensure that client #1 received a timely diagnostic mammogram as recommended. It should be mentioned that the facility medical staff conducts quarterly breast examinations and documents the findings. c. According to client #1's ENT report reviewed at 3:55 PM, client #1 was seen August 7, 2006 and had the right ear wax removed and the left ear wax was partially removed. Debrox for the left ear wax prescribed for one month prior to follow up. There were further instructions to follow up in six months to one year and then have the audiological performed. Client #1 was seen by the audiologist for a (Brainstem Response) BSER on October 31, 2006. The client was diagnosed with excessive cerumen in the left ear. The facility was requested to not return the client until the ears are cleared. The nursing staff failed to follow through on the ENT return visit recommendations prior to attempting the BSER. d. According to the primary physician's notation on an August 7, 2006's consultation document, client #1 had a diagnosis of hypertension. Also noted by the primary physician was that client #1 had an EKG conducted and that the report was to follow. The surveyor and the RN attempted to locate the results of the EKG on May 25, 2007 at 11:53 AM. The report was not available at the facility. There were no follow up notations about	I 391	1. a-d The RN, the Nursing team and the QMRP will ensure that the all client related medical services are obtained in a timely manner. The RN will ensure that diagnostic results are obtained and medical follow for each individual is done in a timely manner. The Nurses will maintain a medical diary to track all medical appointments and necessary follow up. 7/03/07	7/03/07 & Ongoing

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I 391	Continued From page 12 the EKG identified in the following months of summaries by the primary physician. 2. The facility failed to provide safe techniques to encourage client #1 from consuming foods in a fast pace. Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed all of her food. There was no intervention observed or overheard. An interview with client #1's lead day program staff was conducted on May 22, 2007 at 11:20 AM. This interview revealed that client #1 was capable of eating independently; however, the client was monitored to slow down. The client was also prescribed a chopped diet. On May 23, 2007 at approximately 9:00 AM, the surveyor inquired as to rather client #1 had any guidelines for eating as part of her meal plan. A speech report dated November 13, 2006 was reviewed on May 23, 2006 at 9:00 AM. This report reflected "home should continue to use guidelines to promote slow eating rate". Another report noted by speech and dated June 8, 2006 reflected "follow eating and texture guidelines per the speech therapist. A document identified in client #1's training book reflected "pace by using attached slow eating rate protocol". There was no attached protocol. It could not be determined that client #1's rapid eating pace had been addressed through a formal and consistent protocol to prevent possible	I 391	2-3 The QMRP will ensure through periodic mealtime observation that the staff provide interventions that will promote client safety to client #1 and #3. The QMRP will follow up on all the necessary protocols and train staff to adhere to recommendations made by Professional staff at all times. 7/03/07	7/03/07 & Ongoing

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I 391	Continued From page 13 choking. 3. During observations of the the dinner meal conducted on May 22, 2007 beginning at 6:24 PM, Client #3 was observed eating her dinner meal. The client was observed eating very rapidly while staff supervised the table. Interview with the staff #1 on the same day at approximately 7:15 PM indicated that Client #3 eats very fast and has to be prompted to slow down. Review of the Speech and Language Assessment dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist.	I 391	2-3 The QMRP will ensure through periodic mealtime observation that the staff provide interventions that will promote client safety to client #1 and #3. The QMRP will follow up on all the necessary protocols and train staff to adhere to recommendations made by Professional staff at all times. 7/03/07	7/03/07 & Ongoing
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The	I 395	P14-15 1395 Cross Reference "a" 3520.2	

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I 395	Continued From page 14 professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: The findings include: Refer to "a" 3520.2 state licensing report.	I 395		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: The findings include: This GHMR had contracts for Nutrition, Psychology, Occupational and Physical therapy, Speech, and Recreation. Each contract was reviewed on May 24, 2007 at 9:00 AM. Clients #1, #2, #3's charts were reviewed for the purpose of this survey. It was revealed that the professional staff had not provided any assessment or follow up of the clients in this GHMRP since the signing of the professional contracts in January 2007. The findings include: 1. Observation of the evening medication administration conducted on 5/22/07 at beginning	I 401	1401 1 & 2 The QMRP will ensure that Professional staff provide assessments of each client (Clients #1, #2 and #3) based on their discipline. The QMRP will ensure through monthly review of the records that each client has the necessary evaluations required. 7/03/07 & Ongoing	7/03/07 & Ongoing

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I 401	Continued From page 15 at 4:50 PM, revealed Client #3 received Risperdal 1 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 4:57 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 8:49 AM revealed that Risperdal 1 mg by mouth QPM was incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head rubbing, self-harm, and uncooperativeness. Review of Client #3's medical records on 5/23/07 at 8:49 PM revealed that the psychotropic medications was prescribed to address behaviors associated Depression Disorder with Psychotic features and Behavioral Disorder. Further review of the medical records on the same day at approximately 9:15 AM, revealed no documented evidence of a psychiatric assessment. 2. Observation of the evening medication administration conducted on 5/22/07 at approximately 5:31 PM, revealed Client #4 received Buspar 15 mg, Risperdal 2 mg, Tegretol 200 mg, and Revia 30 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 4:57 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 10:16 AM revealed that the psychotropic medications were incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head banging and self injurious behaviors. Review of Client #4's medical records on 5/23/07 at approximately 10:16 AM, revealed no documented evidence of a psychiatric assessment.	I 401	2 The QMRP will ensure that Professional staff provide assessments of each client (Clients #1, #2 and #3) based on their discipline. The QMRP will ensure through monthly review of the records that each client has the necessary evaluations required. 7/03/07 & Ongoing	7/03/07 & Ongoing

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I 404	3520.6 PROFESSION SERVICES: GENERAL PROVISIONS Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident ' s programs and daily activities. This Statute is not met as evidenced by: The findings include: This GHMR had contracts for Nutrition, Psychology, Occupational and Physical therapy, Speech, and Recreation. Each contract was reviewed on May 24, 2007 at 9:00 AM. Clients #1, #2, #3's charts were reviewed for the purpose of this survey. It was revealed that the professional staff had not provided any assessment or follow up of the clients in this GHMRP since the signing of the professional contracts in January 2007. No instructions had been provided by these professional staff. These current professionals had not reviewed the previous work completed by prior professionals even in cases where there were formal programs. For Example: #3 had a behavioral management plan; however, the current psychologist had not evaluated the program or the assessment. Client #2 had a speech program that had not been evaluated by the current pathologist. It could not be determined that the GHMRP implemented that relevant professional instructions on clients; programs and daily activities.	I 404	1404 The QMRP will ensure that whenever a professional staff is new, within 30 days of employment, each client's record will be reviewed and an initial note will be put in place. The professional will be required to put a plan of continuity of services in place. All the above will be made possible with a training for the QMRP. 6/30/07	6/30/07 & Ongoing
I 407	3520.9 PROFESSION SERVICES: GENERAL	I 407		

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FORM APPROVED

Health Regulation Administration

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	09G211	A. BUILDING _____ B. WING _____	05/24/2007

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I 407	Continued From page 17 PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: The findings include: a. There were no psychological quarterly reports for client #1 and #3 who have behavioral support plans. Client #3 was also prescribed medications for behaviors. b. Speech had a formal program for client #2; however, there were no quarterly notations to determine that the professional had monitored the objective recommended.	I 407	P17-18 1407 a & b The QMRP will ensure that Professional staff adhere to the terms of their contract to provide services as indicated therein. The QMRP will in future report to HRDI authorities professional staff who fall short of their professional duties as outlined in their contract. 6/30/07 & Ongoing	6/30/07 & Ongoing
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: The findings include: 1. Client #2's IPPs, documentation, and clinical records were reviewed on May 24, 2007 at 11:40 AM. According to client #2's IPP, the client had a program that read "will improve expressive language skills by using the sign eat for 80% of the opportunities with hand/hand. Observations	I 420		

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I 420	Continued From page 18 of snack times were made on May 22, and 23, 2007 at approximately 4:15 PM each day and a dinner meal on May 22, 2007 at approximately 6:10 PM. There were no attempts observed to have client #2 to sign eat at the given opportunities. 2. During the observation period on May 22, 2007, client #2 was observed to be visually impaired. The House Manager confirmed that client #2 was blind. This diagnosis was also included on the Medical assessment dated January 23, 2007 that was reviewed on May 22, 2007 at 6:00 PM. The psychological assessment dated January 2007 that was reviewed on May 23, 2007 at 3:45 PM reflected that the client should be encouraged to participate in sensory activities including sound, smell, tast, and touch. Further stated was the "it would be helpful to tailor activities around her senses". On May 23, 2007 at 4:03 AM, the House Manager indicated that sensory motor equipment was in the facility. The equipment shown included a sensi- ball switch, vibrating mini bubbles, gooshy switch, oval tax multi sensory, and high music vibration enabling device. These items were inoperable perhaps due to having no batteries. Although music played while all clients were sitting out on their porch, this was the only sensory motor functioning activity provided during the observation. It could not be determined that client #2 had been engaged in the multiple sensory task/activities as recommended. 3. Client #2's IPP and data was reviewed on May	I 420	P18-20 1420 1-3 The QMRP will ensure that staff provide opportunities through the normal course of the day for each client to participate in meaningful activities to enhance skills. Staff will be trained to communicate and provide interventions to clients to meet their health and safety needs. 7/10/07	7/10/07 & Ongoing

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I 420	Continued From page 19 24, 2007 at approximately 11:00 AM. a. Client #2 had an objective which read "will participate in an activity with her peers or staff with verbal assistance". The focus of the program was identified to be "setting the table". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007. The documentation that was reviewed reflected that the client had performed at 0% since January 2007. b. Client #2's had an objective to "stack utensils on top of her plate ". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007.	I 420		
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: The findings include: IPPs and related data collection was reviewed on May 23, 2007 at 11:10 AM. There were no revisions made to programs that had been achieved at the stated criterion level as reflected below. a. Client #1's IPP indicated that the client would complete task with peers using verbal assistance on 4/4/ trials. The documentation reflected that	I 424	P20-21 1424 a & b The QMRP will indicate in her monthly notes the necessary areas where each client needs more focus on indicating the clients progress. The QMRP will assist each client to acquire skills in areas that he/she has not yet mastered. 6/30/07	6/30/07 & Ongoing

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I 424	Continued From page 20 from January 2007 to April 2007, the client performed at 100% verbal prompting thus meeting the criterion level. b. Client #1's financial IPP read that the client would purchase an item on a community outing with visual cues. According to the documentation reviewed, the client performed with 100% verbal prompting from January 2007 to May 2007. Interviews with the direct care staff at the facility interviewed on May 22, 2007 at 5:20 PM and with the direct care staff at the day program on May 22, 2007 at 11:20 AM, client #1 performs purchasing task with verbal prompting coupled with gestures for the actual purchasing exchange. It could not be determined that client #1 had continued to be challeged in her goal areas.	I 424		
I 426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: The findings include: 1. Client #1's IPPs and documentation was reviewed on May 23, 2007 at 11:10 AM. Revisions had not been made to programs that had not been mastered based on the criterion levels. Client #1 had an IPP to brush her teeth with	I 426	P21-23 1426 1-3 The QA Director will in-service the QMRP to review, revise and discontinue programs based on each client's performance-client refusal, client stays at the same level, client achieving program for over three to six consecutive months. Staff will be trained to implement programs as outlined. 6/30/07	6/30/07 & Ongoing

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I 426	Continued From page 21 100% verbal prompting. The documentation reviewed for this program reflected that the client had not met criterion and performed only 66% of the time with verbal prompting, from January 2007 to May 2007. The remaining trials were conducted with physical prompting and 1% independence. There were no revisions to the IPP or objective to encourage the client's success. 2. Client #2's IPPs, documentation, and clinical records were reviewed on May 24, 2007 between 11:40 AM and 12:30 PM. There were no revisions made to programs that had not been mastered based on the stated criterion levels. According to client #2's IPP, the client had a program that read "will improve expressive language skills by using the sign eat in 80% of the opportunities with hand/hand. The IPP was dated to have started in January 2007; however, review of the speech section of the clinical chart, it was determined that the IPP for signing eat was initiated in February 2006 with. There were no changes to the objective since that time. The speech assessment dated October 18, 2006 reflected "continue with her communications program as she demonstrates growth, more basic signs will be added." The documentation reflected that from December 2006 to March 2007 trials were refuses 100% of the trials. April 2007's data reflected 40% hand over hand and 60% refusal, and May 2007 had been recorded at 100% refusals. Although the client continued to unachieve the criterion, there were no revisions to the IPP or the objective.	I 426	1-3 The QA Director will in-service the QMRP to review, revise and discontinue programs based on each client's performance-client refusal, client stays at the same level, client achieving program for over three to six consecutive months. Staff will be trained to implement programs as outlined. 6/30/07	6/30/07 & Ongoing

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I 426	Continued From page 22 3. Client #2 had a program which read "will participate in an activity with her peers or staff with verbal assistance". The focus of the program was identified to be "setting the table". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007. The documentation reviewed reflected that the client performed at 0% from January 2007 to March 2007. It should be mentioned that the documentation reflected that client #2 progressed at 100% in April and May 2007. Inquiry was made to the QMRP as to what took place for such change in performance. There had been no changes made to the program or objective. The QMRP did not elaborate as to what may have precipitated this increased achievement. There evidence did not support that client #2's program had been revised to encourage the client's success in the mastery of this objective.	I 426		
I 429	3521.6 HABILITATION AND TRAINING Each GHMRP Director shall arrange for each resident to be reevaluated and to receive an Individual Habilitation Plan, which is updated appropriately at least annually. This Statute is not met as evidenced by: The findings include: Client #1's assessments, IPPs and documentation were reviewed on May 23, 2007 at 11:10 AM. The IPPs identified in client #1's individual support plan (ISP)dated January 2007 were continued from the previous ISP annual.	I 429	P23-24 1429 Each consultant will review programs at the ISP and the QMRP will ensure that the reason for any continuity will be addressed appropriately. 6/30/07	6/30/07 & Ongoing

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I 429	Continued From page 23 The Occupation Therapy assessment that was reviewed was dated January 30 2006. The recommendations included objectives for toothbrushing, applying lotion, making a store purchase, and completing a task with peers. The assessment further reflected that "these programs are performed on a routine basis and should be continued". The written IPPs reflected that these program criterions and objectives were not revised during the January 2007 individual support plan meeting.	I 429		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: The finding include: 1. The facility failed to provide and teach safe techniques to encourage client #1 to consume her foods in a safe manner. Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed all of her food. There was no intervention observed or overheard. An interview with client #1's lead day program	I 436	P24-26 1436 1 & 2 The QMRP and RN will ensure that a protocol is developed for Client #1 and staff is trained on it. Staff will again be trained on Aspiration Protocol to properly assist Client #3. 6/30/07	6/30/07 & Ongoing

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I 436	Continued From page 24 staff was conducted on May 22, 2007 at 11:20 AM. This interview revealed that client #1 was capable of eating independently; however, the client was monitored to slow down. The client was also prescribed a chopped diet. On May 23, 2007 at approximately 9:00 AM, the surveyor inquired as to rather client #1 had any guidelines for eating as part of her meal plan. A speech report dated November 13, 2006 was reviewed on May 23, 2006 at 9:00 AM. This report reflected "home should continue to use guidelines to promote slow eating rate". Another report noted by speech and dated June 8, 2006 reflected "follow eating and texture guidelines per the speech therapist. A document identified in client #1's training book reflected "pace by using attached slow eating rate protocol". There was no attached protocol. It could not be determined that client #1's rapid eating pace had been addressed through a formal and consistent protocol to prevent possible choking. 2. During observations of the the dinner meal conducted on May 22, 2007 beginning at 6:24 PM, Client #3 was observed eating her dinner meal. The client was observed eating very rapidly while staff supervised the table. Interview with the staff #1 on the same day at approximately 7:15 PM indicated that Client #3 eats very fast and has to be prompted to slow down. Review of the Speech and Language Assessment dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached	I 436	2 The QMRP and RN will ensure that a protocol is developed for Client #1 and staff is trained on it. Staff will again be trained on Aspiration Protocol to properly assist Client #3. 6/30/07	6/30/07 & Ongoing

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I 436	Continued From page 25 form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist.	I 436		
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: The finding includes: 1. Client #2's IPPs, documentation, and clinical records were reviewed on May 24, 2007 at 11:40 AM. According to client #2's IPP, the client had a program that read "will improve expressive language skills by using the sign eat for 80% of the opportunities with hand/hand. Observations	I 437	P26 1437 The QMRP will train staff to assist Client #2 to sign eat at mealtime. The staff will assist her to meet her needs and promote independence. 6/30/07	6/30/07 & Ongoing

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I 437	Continued From page 26 of snack times were made on May 22, and 23, 2007 at approximately 4:15 PM each day and a dinner meal on May 22, 2007 at approximately 6:10 PM. There were no attempts observed to have client #2 to sign eat at the given opportunities.	I 437		
I 443	3521.7(m) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (m) Financial management (including budgeting and banking); This Statute is not met as evidenced by: The findings include: Client #1's financial IPP read that the client would purchase an item on a community outing with visual cues. According to the documentation reviewed, the client performed with 100% verbal prompting from January 2007 to May 2007. Interviews with the direct care staff at the facility interviewed on May 22, 2007 at 5:20 PM and with the direct care staff at the day program on May 22, 2007 at 11:20 AM, client #1 performs purchasing task with verbal prompting coupled with gestures for the actual purchasing exchange. It could not be determined that client #1 had continued to be challeged in her goal areas.	I 443	1443 The QMRP will review Client #1's program and ensure that a more challenging program is put in place to better meet her needs. 6/30/07	6/30/07 & Ongoing
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and	I 500		

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I 500	Continued From page 27 protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: The findings include: 1. Observation of the evening medication administration conducted on 5/22/07 at beginning at 4:50 PM, revealed Client #3 received Risperdal 1 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 4:57 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 8:49 AM revealed that Risperdal 1 mg by mouth QPM was incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head rubbing, self-harm, and uncooperativeness. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on 5/23/07 at approximately 11:12 AM revealed that Client #3 did not have a legal guardian, but her sister used to be involved in her life. The House Manager indicated that the facility has not been able to contact the sister. Review of Client #3's Psychological Assessment dated 11/30/06 on 5/23/07 at approximately 11:35 AM revealed that she is unable to give informed consent and requires 24-hours a day supervision in a group home in order to function in a community setting. The assessment also revealed that Client #3 is not competent to make independent decisions concerning her treatment, placement, or finances. There was no documented evidence that the facility informed Client #3 or a legally-authorized representative, as appropriate, of the health benefits and risks of	I 500	P27-30 1500 1 & 2 The QMRP will in future inform Client #3 and #4 of restrictive controls being administered, the use of a Behavior Support Plan to address inappropriate behaviors and other restrictive interventions. The QMRP will ensure that significant legal representatives of these individuals provide a consent of restrictive techniques used. 6/30/07	6/30/07 & Ongoing

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I 500	Continued From page 28 treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. Observation of the evening medication administration conducted on 5/22/07 at 5:31 PM, revealed Client #4 received Risperdal 2 mg, Buspar 15 mg, Tegretol 200 mg, and Revia 25 mg crushed into applesauce by mouth. Interview with the medication nurse staff on the same day at approximately 5:35 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 4/1/07 on 5/23/07 at approximately 10:16 AM revealed that the psychotropic medications were incorporated in a Behavior Support Plan (BSP) dated 6/7/06, to address behaviors associated with head banging and self-injurious behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on 5/23/07 at approximately 11:12 AM revealed that Client #4 did not have a legal guardian, but her sister and father is involved in her life. Review of Client #4's Psychological Assessment dated 11/30/06 on 5/23/07 at approximately 12:30 PM revealed that she is unable to give informed consent and requires 24-hours a day supervision. The assessment also revealed that Client #4 is not competent to make independent decisions concerning her treatment, placement, or finances. There was no documented evidence that the facility informed Client #4 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP.	I 500	2 The QMRP will in future inform Client #3 and #4 of restrictive controls being administered, the use of a Behavior Support Plan to address inappropriate behaviors and other restrictive interventions. The QMRP will ensure that significant legal representatives of these individuals provide a consent of restrictive techniques used. 6/30/07	6/30/07 & Ongoing

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G211	A. BUILDING _____ B. WING _____	05/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HRDI OF THE DISTRICT OF COLUMBIA, LLC	3073 VISTA STREET, NE WASHINGTON, DC 20018

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I 500	Continued From page 29 Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 3. Refer to federal deficiency report (W124, W125, W263).	I 500	3. Cross Reference W124, W125 and W263	6/30/07 & Ongoing